



Medicare Lifetime Signature on File:

I request that payment of authorized Medicare benefits be made on my behalf to Charlottesville Family Medicine for any services furnished me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

Patient Signature

Date

We are required by law to maintain privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. Signature below is only acknowledgement that you agree with the Notice of our Privacy Practices.

I hereby authorized insurance benefits be paid to Charlottesville Family Medicine, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers. If my account becomes assigned to a collection agency, I agree to pay all cost of collection, including 25% of agency fees, court costs and attorneys fees.

Print Name

Signature

Date

DEEMED CONSENT FORM

I understand that the laws of Virginia provide if my physician, or any person employed by or under the direction and control of my physician(s), is directly exposed to my body fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immuno-deficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my body fluids.

Date: _____

Patient Name: _____

Witness: _____